California Newborn Hearing Screening Program
Outpatient Screening Reporting Form

Please complete this form and Fax to 925-947-5680 or 925-947-4318 or Mail to the Bay Area/Northern California Hearing Coordination Center, 3480 Buskirk Avenue, Suite 125, Pleasant Hill, CA 94523, within seven days of the child's outpatient hearing screening. DO NOT attach waveforms, OAE printout, audiograms or reports. **If the family does not appear for the scheduled appointment and you have difficulty in rescheduling the outpatient hearing screening, please contact the Hearing Coordination Center at 925-941-7933.**

I. Screening Provider: _____ Phone: _____ Fax: _____

Infant's Name: _____ Date of Screen:_____

AKA: _____ Date of Birth: _____ Gender: ☐Female ☐Male

Primary Care Provider (PCP): _____ Phone: _____

Birth Hospital: _____ ☐WBN ☐ NICU County: _____

Insurance: ☐Medi-Cal ☐HMO ☐Private Insurance ☐Uninsured ☐Unknown

Mother's Name (or Legal Guardian): _____

Address: _____ Phone Number: _____

Primary Language: ☐English ☐Spanish ☐Other (specify)_____

Comments: _____

_____

II. Screening Results: ☐ Initial Screen (1st, no previous screening inpatient or outpatient) ☐ Re-screen (2nd)

	DPOAE	TEOAE	ABR(Screening)
Right Ear	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer
Left Ear	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer

III. For infants who do not pass the outpatient screening:

Referral to CCS

Name of County: _____ Date: _____

Family's CCS application was forwarded to local CCS program ☐Yes ☐No

Referred for Diagnostic Evaluation

Name of Provider: _____ Phone: _____

Date of Appointment: _____ Reason appointment not scheduled: _____

Contact Information (Relative or Friend):

Name: _____ Phone:_____

Address: _____ Relationship: _____

IV. Parent/Guardian Refused Services: ☐Yes Refused by: _____

V. Parent/Guardian Contact Attempts: Document at least 3 attempts to contact the family.

1. Contact: ☐ Mail ☐ Phone ☐ Fax Date_____ Result: _____
2. Contact: ☐ Mail ☐ Phone ☐ Fax Date_____ Result: _____
3. Contact: ☐ Mail ☐ Phone ☐ Fax Date_____ Result: _____

This information is to be provided pursuant to Section 124119 of the California Health and Safety Code that requires you to report the results of audiological follow-up services provided through the California Newborn Hearing Screening Program.